GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

OFFICE ON DISABILITIES AND AGING

MEMORANDUM

TO: HCFA STAFF INVOLVED IN DC EXPANSION WAIVER

FROM: STEVEN LUTZKY, CHIEF, OFFICE ON DISABILITIES AND AGING

SUBJECT: RESPONSES TO HCFA QUESTIONS RAISED PRIOR TO 12/15 MEETING

DATE: DECEMBER 14, 2000

This memorandum summarizes our proposed responses to the questions posed by the HCFA reviewers. We will modify these responses after obtaining input from the reviewers. Each HCFA question is repeated in italicized print, followed by an initial MAA response. Note that several of the issues I-ICFA has raised cannot be fully addressed at this time, although these issues will be resolved as the developmental process continues.

Target Population

I. Please describe plans/process for outreach efforts to target population. How will the District reach this targeted population and ensure that they are enrolled in the waiver or placed on the waiting list?

DC's Medical Assistance Administration (MAA) and the Administration for HIV AIDS (AHA) will be responsible for notifying potential waiver enrollees about the Medicaid coverage initiative. The outreach effort will work as follows:.

- We will draw upon the many Ryan White funded entities throughout the District to develop lists of potential waiver enrollees.
- We will then work with the Ryan White agencies regarding the most appropriate ways of disseminating information about the waiver to the targeted individuals.
- We will also contact medical providers who are known to treat HIV± individuals, and facilitate their dissemination of waiver announcement/education materials to their HIV± patients.
- Some forms of broad community notification will also be used, to attempt to reach persons who are infected but have not regularly accessed medical care and social support services.

We are in the process of transforming this outline into a detailed outreach plan.

2. Please clarify the number and demographic characteristics (e.g., gender, age, race/ethnicity) of the reported cases of AIDS in the District as well as the estimated number and demographic characteristics of the HIV positive (both HIV and AIDS) population on Medicaid in the District.

Attachment I presents a series of data tables related to the waiver initiative. Tables H-J of Attachment I provide distributions of the District's reported AIDS cases by gender, age and race/ethnicity in 1998. Parallel distributions

for District residents with asymptoniatic and symptomatic HIV are not available. This information complements the data regarding HI V-infected Medicaid beneficiaries in the District presented in Tables C and D.

Program Design

1. *We believe that the District proposes that there will be no resource test for this group. Is our understanding correct? On page 8, in the second paragraph that describes the eligibility expansion criteria, die District indicates that it will disregard the resource rules outside of the 100% FPL income criteria.*

The District does not plan to use any resource rule in addition to the 100% FPL income criteria. We initially considered several options in this regard. We omitted a resource rule in order to simplify the administrative tasks regarding eligibility determinations.

2. *The District currently has another 1115 application submitted to HCFA for an expansion of Medicaid to childless adults 50-64 years old In that waiver application, they want to exclude people with HIVD and have them enroll in the HIV Expansion waiver being proposed here. However, in this application, enrollment into the HIV waiver would be on a first-come first-served basis. Has the District considered options if these adults are precluded from this waiver due to the enrollment cap?*

Between 7% and 11% of the District's population living with AIDS is over 50 years old. By assuming a similar income distribution within each age group of people living with HIV/AIDS, we estimate that roughly 35 to 54 persons who are eligible for the HIV Waiver would be in this age category. The District will enroll these individuals in the HIV waiver on a priority basis during initial waiver enrollment.

In order address ADA concerns with the 50-64 year old waiver going forward, the District proposes to keep several Waiver spots "open" for the *50-64* year old population who may come forward at any time after the program begins.

3. *How will the District operate the waiting list? Describe the procedures for placing individuals on the waiting list and the criteria and process that will be followed in moving individuals from the waiting list to the waiver Include the frequency with which enrollment will be monitored and Medicaid and waiver eligibility determinations conducted*

As noted above, first priority will likely be given to infected persons in the 50-64 age group, to assure that low-income infected individuals are not left without coverage versus persons of similar income and age who are able to enroll in the other expansion waiver.
We have implemented a contract with The Lewin Group to supply the District with assistance in developing a detailed implementation plan for the program. This plan will address these issues...

4. *Please clarify and provide more detail about how the District plans to coordinate the services provided under the Ryan White Care Act program, particularly the AIDS Drug Assistance Program and this Medicaid waiver*

The District will coordinate services with the relevant programs and agencies in several important ways. Specifically, the N4AA and AHA will collaborate to:

- provide an initial Medicaid eligibility screening at first contact and move all eligible participants into Medicaid;
- provide ADAP coverage' to all Medicaid eligible individuals who are on the Waiver waiting list; and

- through the treatment adherence initiative, provide adherence education to all ADAP, Medicaid, and Waiver enrollees.

Presently, the ADAP provides free drug assistance that covers a wider range of the HIV/AIDS population. The eligibility criteria are far less restrictive for income (300% of poverty).

As well, other Ryan White services (e.g. better nutrition, complementary therapies, case management, emergency financial assistance, legal assistance, etc.) will be provided to all participants in ADAP, Medicaid, the Waiver, and/or on the Waiver waiting list. This has traditionally been the standard procedure for those who are awaiting Medicaid approval in the District of Columbia.

Talks to explore these scenarios as well as other aspects of the waiver implementation are taking place between the MAA, AHA, and their community partners. These entities have worked together with the larger community to provide input to the development of the program design of the expansion waiver application.

To the extent that persons currently served by ADAP enroll in the Medicaid waiver, ADAP slots will be freed up. Thus, an important side-effect of the Medicaid waiver is that it may become possible to raise the ADAP income threshold and further strengthen access to HAART among the District's HIV-l- population.

S. *In previous discussions, the District has proposed restricting pharmacy access for discounted drugs. What is the status of the discussions on this issue?*

The District is exploring all options that would allow all District Medicaid pharmacies to participate. Based on our current understanding of the FSS ordering and distribution process, there will be no need to restrict pharmacy access. Sandi Murbach and Carol O'Brien at FSS suggest that the drug manufacturers will deliver to each of the Medicaid pharmacies as the orders are processed using the Prime Vendor arrangements and software. The District will promptly notify HCFA if we learn that pharmacy access may be affected during our subsequent discussions with the Federal Supply Service. The contract with Lewin to provide supplemental assistance includes addressing this issue.

6. *Page 8 (last paragraph) states ... the District would not have to restrict pharmacy or provider access among HI V-infected patients in order to secure the FSS-priced drugs. Given that there are approximately 200 locations (retail establishments) where clients can get prescriptions filled in D.C., how will these locations access ESS pricing?*

Please see response to #5 above.

Benefit Package

I. What are the specifics of the "planned treatment adherence project?"

The District is not seeking to include the adherence initiative in the waiver benefit. However, we recognize that ensuring treatment compliance is crucial to the success of this demonstration. Therefore, we have, in conjunction the HIV Consortium that assisted in the development of the waiver, been collaborating with District agencies and community partners to develop refine existing treatment adherence protocols and ensure that waiver recipients access them. The adherence project will be funded by RWCA allocations, and it is proceeding on a separate though parallel track to the Waiver.

2. What is the District's rationale for not including case management services as part of the benefit package?

The District chose to fund case management outside of the waiver to maximize the number of individuals we could enroll under the waiver Because the District currently does not have a mechanism for paying for case management

for this population in the regular Medicaid program, covering case management under the waiver would add to the total cost of the waiver. Because these costs must be offset by the prescription drug savings, this additional cost would have resulted in our having to reduce the number of waiver slots. Instead, MAA and AHA decided to fund these services through RWGA-funded entities for persons living with
EIIV/AIDS.

Research and Evaluation

I. What are the specifics of the District's quality improvement monitoring effort for this waiver? How will non-pharmacy utilization, access, and quality of care be assessed?

Baseline data on the District's Medicaid population are being developed by the Lewin Group through a project funded by the Kaiser Family Foundation. The Lewin Group will be working with MAA and AHA to develop a waiver monitoring and evaluation plan during early 2001. Lewin's consulting scope of work is shown in Attachment 2.

Estimation of Costs/Savings and Budget Neutrality

1. Please discuss the specifics and steps of the UCSF model and fully describe the development of the proposed budget neutrality calculation. Please be specific regarding the process to calculate with and without waiver costs, and data sources for each calculation/estimate. Please provide the actual electronic model used for the calculation. How would you go about reconciling the estimates in the UCSF model with the cost and trend estimates implied in the Medicaid baseline in the President's Budget?

The process through which the model generates baseline and waiver costs is discussed in detail in the manuscript and technical appendices by Kahn et al, which were included with the waiver submission. In Attachment I, Table A, we have also summarized the modifications made to tailor the model to the local context.

The Lewin Group is contractually prohibited from sharing the model with any outside party. We therefore suggest that HCFA request direct access to the model from the owner, Dr. James G. Kahn at the University of California, San Francisco. Dr. Kahn can be reached at (415) 476-6642.

The expenditure estimates in the 1115 application reflect Medicaid costs over a five-year waiver period in 1998 dollars. The five-year window was chosen to conform to CBO and 0MB conventions for budget scoring. Final waiver cost figures will be produced once the value of the HIV drug discount has been updated, which will drive the determination of the program's initial enrollment ceiling. These figures can be produced in 1998 dollars, or in inflation-adjusted dollars – whichever approach is preferred by HCFA and/or 0MB. The trending assumptions used are likely to have a modest impact on the program's enrollment ceiling.

2. Please provide DC-specific historical per person costs for all HI V-positive persons enrolled in Medicaid Submit these data for all years (e.g., 1996 and beyond) in which highly active antiretroviral therapy (HAART) was provided to Medicaid enrollees. In addition, separately report these costs for HI V-positive individuals who are asymptomatic, symptomatic or have AIDS. Include the algorithm that is used to identify HI V-positive Medicaid enrollees and claims paid on their behalf

The DC Medicaid fee-for-service expenditures for adult HIV-infected beneficiaries during FY 1996-1998 are reported in Table B. You will note a difference in these figures and the estimate used in the model (i.e., $38.1 million). This difference is explained by at least two factors:

The data in Table B do not reflect the pharmacy rebates "refunded" to DC Medicaid in periodic settlements. In contrast, the pharmacy rebates are incorporated into the model.

- The data in Table B represents more up-to-date and complete claims data than those available at the time the

model estimates were generated; these data yield a slightly different disease distribution and cost estimates.

The data for FY 1996 produce a comparatively high estimate for Medicaid spending for AIDS. This is primarily attributable to high inpatient expenditures. We are not certain as the extent to which this represents a shift in disease distribution, relatively lower utilization of HIV medications, and/or normal variation in expenditures. Data for FY 1997 and FY 1998 yield a more consistent estimate for cost per client month.

Per HCFA's request, we have attached additional information regarding the l-IIV disease coding net developed by Julia Hidalgo, Sc.D. The coding net uses a series of ICD-9-CM codes for HIV, AIDS, and conditions included in the 1993 CDC AIDS Surveillance Case Definition and NDC codes for antiretroviral medications to identify HIV infected persons in Medicaid claims data (Tables F-C). Individuals with claims for certain combinations of these codes are classified as persons with AIDS, and other combinations indicate HIV infection that has not yet progressed to AIDS (see Figure 1). Given the absence of clinical information (e.g., laboratory test results, etc.) in the Medicaid claims data, it is not possible to disaggregate beneficiaries and costs into more than two disease states (HIV and AIDS).

3. *Please provide a historical breakdown of HIV-positive Medicaid enrollees by eligibility category. Submit these data for all years in which HAAR T therapy was provided to Medicaid enrollees.*

The historical comparisons of adult HIV-infected Medicaid enrollees by eligibility code are presented in Table C. Additionally, data broken down by eligibility code, sex and disease status is reported in Table D.

4. *P1ease provide update on your negotiations to secure a drug discount through the Federal Supply Schedule (FSS). How confident is the District that it will he able to obtain discounts of 15 25% off the current Medicaid prices?*

In terms of the drug discount with the Federal Supply Schedule, the District has received several assurances from Sandi Murbach at the Federal Supply Service. She and her colleagues have again confirmed that the District has FSS access and discussed with us some of the operational aspects of using the FSS. Generally, Ms. Murbach is encouraging about the District's prospective use of the FSS system.

We are planning an operational meeting with Ms. Murbach, FSS pharmacy officials, and the relevant District agencies for early- to mid-January. We hope to discuss Prime Vendor, the pharmacy distribution network, and related issues at that meeting.